STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15K080		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE A. BUILDING 00 COMPLETED B. WING 03/27/2015					
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 107 FEDERAL DRIVE CHESTERFIELD, IN 46017				
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE
G 000							
Bldg. 00			G 0	00	Plan of correction completed a submitted	and	
		or a home health federal rvey. This visit resulted ded survey.					
	Survey date: 3/2	23/15 - 3/27/15					
	Facility #: 0126	85					
	Medicaid Vendo	r #: 201058730					
	Surveyor: Ingric	Miller, PHNS, RN					
	Skilled unduplication	ated census: 23					
	Quality Review: BSN, RN March 3	Joyce Elder, MSN, 1, 2015					
G 121 Bldg. 00	accepted profession principles that app furnishing services	STD taff must comply with onal standards and ly to professionals	G 1:	21	The DON/ADON held an		04/03/2015
	Based on observa	ation, interview, and	G I	41	THE DOIN/ADOIN HEIR AIT		04/03/2015

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/28/2015 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15K080		A. BUILDING 00 B. WING			COMPLETED 03/27/2015		
	PROVIDER OR SUPPLIER			107 FEI	ADDRESS, CITY, STATE, ZIP CODE DERAL DRIVE ERFIELD, IN 46017		
	summary structure (EACH DEFICIENCE REGULATORY OR review of policie agency failed to a aide had provided with infection coprocedures in 1 cobservations (Pathealth aide (Empadide)). Findings 1. At a home vis 3/25/15 at 2 PM, Health Aide, was patient #3. When her gloves after repatient #3, she against without washing prior to giving a 2. On 3/25/15 at	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) Is and procedures, the ensure the home health d services in accordance introl policies and of 3 home visit tient #2) with a home bloyee E, Home Health sit observation on Employee E, Home s observed at the home of en Employee E took off removing clothing from oplied clean gloves her hands. This was shower to patient #3.		107 FEI	DERAL DRIVE	ds d as ad ial vee for aff e	(XS) COMPLETION DATE
	3. The agency production of the second of th	rocedure titled "Standard I Procedures for Home e of August 2002 stated, Fore and after client care.			DON/ADON will ensure that the deficiency is corrected and will not occur in the future	-	
G 141	484.14(e) PERSONNEL POL	LICIES					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

Y5PS11

Facility ID: 012685

If continuation sheet

Page 2 of 24

STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X2) MULTIPLE CONSTRUCTION (X3) DATE		(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPL	ETED
		15K080	B. W	NG		03/27/2015	
				CTDEET /	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER				DERAL DRIVE		
LIFESTY	LES HOMECARE L	LC			ERFIELD, IN 46017		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID		DROWINERS BLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	'	DATE
Bldg. 00	Personnel practice	es and patient care are					
-	supported by appr policies.	opriate, written personnel					
	Personnel records licensure that are	include qualifications and kept current.					
	Based on policy	and employee file review	G 1	41	Based on this deficiency above		03/30/2015
	and interview, th	e home health agency			the following addendums have		
	•	nome health aides were			been made to the home health aide hiring requirements. If a C	-	
	entered on and ir	n good standing on the			is hired to fill a home health air		
		y for 2 of 4 home health			position the CNA must comple		
	aide files review	•			and pass the written home hea		
	aide illes leview	cu (1 , G).			aide exam. The CNA must als	0	
	Findings:				complete the competency evaluation check off with proficiency by the RN. The ho		
	and first patient of evidence the hon	e F, date of hire 4/9/13 contact 4/15/13, failed to me health aide was a good standing on the y.			health aide must be entered or and in good standing with the state aide registry. A copy of the employees current license certification shall be maintaine his/her personnel file. The CNA in question on the deficiency w	n ne d in A's	
	and first patient of evidence the hon	e G, date of hire 3/28/14 contact 3/29/14, failed to me health aide was a good standing on the y.			corrected on 3/30/15		
	administrator, in	10:45 AM, Employee A, dicated Employees F and red on the state aide ome health aides.					
	Registration, or o	olicy titled "License, certification ith no date stated, "If a					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

Y5PS11

Facility ID: 012685

If continuation sheet

Page 3 of 24

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/28/2015 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUR			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPL	ETED
		15K080	B. WIN	G		03/27/	2015
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 107 FEDERAL DRIVE CHESTERFIELD, IN 46017				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE
G 158 Bldg. 00	be the employee' these documents employee's curre shall be maintain file."	F PATIENTS, POC, MED					
	established and podoctor of medicine medicine. Based on clinical policy review and failed to ensure suprovided in account orders in 3 (#2, #1) reviewed. The findings included	eriodically reviewed by a e, osteopathy, or podiatric of record and agency d interview, the agency services had been redance with physician # 5, #7) of 10 records of the resource of the records of the records of the resource of the records of the record of the records of the record of the records of the record of the records of the records of the records of the records of the record of the records of the record of the records of the reco	G 158	8	The DON/ADON held a meetin with all RN's and LPN's. The inservice education meeting content included discussion of policy "Standards of practice", Policy #C-110. The meeting wheld on 4/3/2015. Policy includin section #3 of this policy that client care will be provided und the Plan of Care established be physician. All nursing visits are be followed by the orders on the plan of care signed by the physician. Instructed the RN's and LPN's that if the informal caregiver and/or power of attorney for the patient has requested something to not be done that is on the care plan, physician must be notified and	the as des der y a e to he	04/03/2015
		an of care evidenced			careplan updated. The RN's a		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

Y5PS11

Facility ID: 012685

If continuation sheet

Page 4 of 24

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		JILDING	00	COMPL	
		15K080	B. W	ING		03/27/	2015
NAME OF D	PROVIDER OR SUPPLIER		•	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	ROVIDER OR SUFFLIER			107 FEI	DERAL DRIVE		
	LES HOMECARE L			CHEST	ERFIELD, IN 46017		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	LPN's reeducated that vital sig	20	DATE
		l be done at each skilled			include all the following: blood	115	
		killed nurse visits on			pressure, heart rate, respiratio	ns	
	· ·	, 2/20/15, 2/21/15,			and temperature, If one of thes		
	2/22/15, 2/23/15	, 2/24/15, 2/25/15,			are requested to be omitted, th		
	2/26/15, 2/27/15	, 2/28/15, 3/1/15, 3/2/15,			physician is to be notified and	the	
	3/3/15, 3/5/15, a	nd 3/6/15, blood pressure			careplan should specifically reflect this. 10% of all clinical		
	was not taken.				records will be audited quarter	lv	
					for evidence that standards of	.,	
	2. Clinical recor	rd #7, start of care 9/1/12			practice/plan of care physician		
	and diagnosis of				orders are being followed with		
	_	ided a plan of care for			accuracy. Inservice education		
	· ·	period of 2/18/15 -			meeting for clinical documentation policy #C-680		
		an of care evidenced			held on 4/3/15 by DON/ADON	l If	
	_	d be done at each skilled			a missed visit occurs, a missed		
	_	killed nurse visits on			visit report will be completed.	Γhe	
					reason services were not		
	· ·	, 2/20/15, 2/21/15,			provided and documentation to		
	· ·	, 2/24/15, 2/25/15,			include the physician was notife. The nursing staff will follow this		
	· ·	, 2/28/15, 3/1/15,			policy that is in place. 10% of a		
		/5/15, and 3/6/15, blood			clinical records will be audited		
	pressure was not	taken.			quarterly for evidence that all		
					visits are being followed on the	•	
	On 2/26/15	at 1:35 PM, Employee A,			plan of care signed by the physician, or that a missed visi	i+	
	the administrator	r, indicated the plan of			report was completed, reason		
	care had not bee	n written correctly for			the missed visit and that the	.5.	
	clinical records #	#2 and #7. The informal			physician was notified per poli	су	
	caregiver and po	wer of attorney for the					
		want the patients to have					
	_	done at each visit.					
	Regarding a mis visit	sed home health aide					
	3. Clinical recor	rd #5, start of care 4/1/14					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

Y5PS11

Facility ID: 012685

If continuation sheet

Page 5 of 24

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/28/2015 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER: 15K080	A. BUILDING 00 B. WING			COMPLETED 03/27/2015	
	ROVIDER OR SUPPLIER			107 FEC	DDRESS, CITY, STATE, ZIP CODE DERAL DRIVE ERFIELD, IN 46017		
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	plan of care for to 1/26/15 - 3/26/15 identified the hory visit the patient 4 A. The record health aide visits of 2/2/15 - 2/8/15 on 2/2/15, 2/4/15 no documentation been contacted domain and been contacted documented, not 4. The agency por Care" with no daystaff shall promp	olicy titled "Plan of te stated, "Professional tly alert the physician to suggest a need to alter					
G 224 Bldg. 00	484.36(c)(1) ASSIGNMENT & I HEALTH AIDE	DUTIES OF HOME					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

Y5PS11

Facility ID: 012685

If continuation sheet Page 6 of 24

STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPL	ETED	
		15K080	B. W	ING		03/27/	2015	
				STREET	ADDRESS, CITY, STATE, ZIP CODE			
NAME OF PROVIDER OR SUPPLIER					DERAL DRIVE			
LIEESTV	LES HOMECARE L	1.0			ERFIELD, IN 46017			
				CITEST	ENTILLE, IN 40017			
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
		re instructions for the						
		must be prepared by the						
	1 -	r other appropriate						
		s responsible for the home health aide under						
	paragraph (d) of the							
		no occuon.	G 2	24	The DON/ADON held an		04/03/2015	
			102	4	inservice/education meeting for	or	04/03/2013	
	, ,				all RN's to review the policy fo			
		policy review, clinical			"Careplans" Policy # C-660. The			
		nd interview, the agency			survey deficiency recognized of			
	failed to ensure t	he registered nurse			of the careplans were not sign			
	updated the hom	e health aide plan of care			by an RN that it was reviewed			
	_	days as required by			during the 60day recertification			
		1 of 7 clinical records			visit. All RN's reeducated that			
	• • •				policy reads the care plan sha reviewed, evaluated and revise			
		ents receiving home			at a minimum of every 60 days			
	health aide servi	ces (#3).			and as needed based upon the			
					clients health status, ongoing			
	Findings include	:			client assessments, caregiver			
					support systems, and			
	1 The noticy tit	led "Home Health Aide			effectiveness of the intervention	ns		
		no date stated, "The			in achieving progress toward			
					goals. All updated entries mus	t be		
		re Plan shall be reviewed			signed and dated by the			
	and updated by t	he registered nurse			Registered Nurse. All changes	3		
	minimally every	60 days.			will be communicated to			
					appropriate staff members. The policy will followed by evidence	-		
	2. Clinical recor	rd #3, start of care			clinical records to be free of th			
		ed a physician's plan of			deficiency with each quarterly	.~		
	·	tion period 3/13/15 -			evaluation of a minimum of 10	%		
		•			of clinical records reviewed.			
		cord evidenced an aide						
	_	view dates of 7/18/14,						
	9/11/14, 11/10/1	4, and 3/11/15.						
	3. On 3/26/15 at	3:26 PM, Employee A,						
		r, indicated the aide care						
		<i>'</i>						
	pian snouid be re	eviewed every 60 days.						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

Y5PS11

Facility ID: 012685

If continuation sheet Page 7 of 24

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:					(X3) DATE COMPL		
		15K080	B. Wl	B. WING			/2015
	PROVIDER OR SUPPLIE		STREET ADDRESS, CITY, STATE, ZIP CODE 107 FEDERAL DRIVE CHESTERFIELD, IN 46017				
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
G 331 Bldg. 00	assessment visit care and support for Medicare patie for the Medicare including homebod Based on clinical interview, the agregistered nurse assessment visit aide visited for (#4). Findings included 1. Clinical reconstruction 2/26/15 and diagreed contained a horn conducted by the at 8 AM - 6 PM start of care assessment visit assessment had Employee F we on 2/26/15 at 8	e must conduct an initial to determine the immediate needs of the patient; and, ents, to determine eligibility home health benefit, bund status. al record review and gency failed to ensure the completed an initial before the home health 1 of 10 records reviewed e: rds #1, start of care gnosis of hyponatremia, he health aide visit to employee F on 2/26/15. The RN conducted the essment on 2/26/15 from a. at 4 PM, Employee A, andicated the initial and start of care (SOC) not occurred when the int out to visit the patient	G 3	31	The DON/ADON held an inservice/education meeting of 4/3/15 for all staff regarding the policy for admission of a patie. The policy indicates the service will be initiated after the assessment by the RN, unless documentation supports altern plans based on the client need and wishes. The deficiency indicated the home health aid completed a home visit prior to the RN doing the initial assessment visit. Reeducation completed to all the home health aid assessment visit. Reconcept a call by a client need them to come for their care, the home health aide must first not the office so that coordination the start of care is effective for the safety of the client and the caregiver. The RN is reeducated to inform the client that he/she must notify the office of any hospital admission or discharges that the much needed care not overlooked by the agency avoid the client being without correct care. This policy will be followed by all staff	ne ent. ces s nate ds e o n alth en to ing ne otify of rected e is and the	04/03/2015

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

Y5PS11

Facility ID: 012685

If continuation sheet

Page 8 of 24

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/28/2015 FORM APPROVED OMB NO. 0938-0391

		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED
		15K080	B. WING		03/27/2015
	PROVIDER OR SUPPLIER		107 FE	ADDRESS, CITY, STATE, ZIP CODE EDERAL DRIVE FERFIELD, IN 46017	
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	E COMPLETION
N 000					
Bldg. 00	Survey date: 3/2 Facility #: 1268: Medicaid Vendo Surveyor: Ingrid Skilled unduplication	5 r #: 201058730 l Miller, PHNS, RN	N 000	Plan of correction completed submitted	d and
N 458 Bldg. 00	March 3 410 IAC 17-12-1(f Home health agen administration/mai Rule 12 Sec. 1(f) employees shall b policies. All emplo Indiana shall be so certification, or reg perform the respective records of employ health services sh	procy nagement Personnel practices for e supported by written eves caring for patients in subject to Indiana licensure, gistration required to ctive service. Personnel ees who deliver home all be kept current and mentation of orientation to			

State Form Event ID: Y5PS11 Facility ID: 012685 If continuation sheet Page 9 of 24

STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	ILDING	00	COMPL	ETED
		15K080	B. WI	NG		03/27/	/2015
				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER	8			DERAL DRIVE		
LIFESTY	LES HOMECARE L	LC			ERFIELD, IN 46017		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY		DATE
	(1) Receipt of job(2) Qualifications						
	· ,	ited criminal history					
	pursuant to IC 16-						
		rent license, certification,					
	or registration.						
		mance evaluations.]				
	Based on policy	and employee file review	N 4	58	Based on this deficiency above		03/30/2015
	and interview, th	ne home health agency			the following addendums have been made to the home health		
	failed to ensure l	home health aides were			aide hiring requirements. If a C	-	
	entered on and in	n good standing on the			is hired to fill a home health air		
		y for 2 of 4 home health			position the CNA must comple		
	aide files review	•			and pass the written home health		
	aide illes leview	cu (1, G).			aide exam. The CNA must also complete the competency evaluation check off with		
	Fin din and						
	Findings:						
					proficiency by the RN. The how health aide must be entered or		
		le F, date of hire 4/9/13			and in good standing with the	11	
	_	contact 4/15/13, failed to			state aide registry. A copy of the	ne	
	evidence the hor	ne health aide was			employees current license		
	entered on and in	n good standing on the			certification shall be maintaine		
	state aide registr	V.			his/her personnel file. The CN		
					in question on the deficiency w	vere	
	2 Employee Fil	le G, date of hire 3/28/14			corrected on 3/30/15		
		contact 3/29/14, failed to					
	•	ne health aide was					
		n good standing on the					
	state aide registr	у.					
		10:45 AM, Employee A,					
	-	dicated Employees F and					
	G were not enter	red on the state aide					
	registration as ho	ome health aides.					
	4. The agency po	olicy titled "License,					
	Registration, or	-					

State Form Event ID: Y5PS11 Facility ID: 012685 If continuation sheet Page 10 of 24

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUF			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPL	ETED
		15K080	B. W	ING		03/27/	2015
	PROVIDER OR SUPPLIER		<u> </u>	107 FE	ADDRESS, CITY, STATE, ZIP CODE DERAL DRIVE ERFIELD, IN 46017		
(X4) ID	SIIMMADVS	FATEMENT OF DEFICIENCIES	I	ID			(X5)
PREFIX TAG	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION DATE
N 470 Bldg. 00	position requires be the employee's these documents employee's curre shall be maintain file." 410 IAC 17-12-1(n Home health agen administration/mai	ncy nagement					
	shall be written an control of communicompliance with a laws. Based on observative review of policies agency failed to aide had provide with infection comprocedures in 1 conservations (Pathealth aide (Emparadie)). Findings 1. At a home vis 3/25/15 at 2 PM,	ation, interview, and as and procedures, the ensure the home health d services in accordance entrol policies and	N 4	70	The DON/ADON held an inservice for all nursing staff of 4/3/15 on "Standard infection control procedures" Policy #N-100 Policy purpose is to provide protection against the transmission of infection. To comply with the guidelines of OSHA and CDC in creating a safe environment for all health care workers and other caregivers in the home setting Part one of the procedure specifically reads to wash han before and after client care an after removing gloves. Handwashing policy #N-100 h a purpose to prevent the spread of infection by contaminated	ds d	04/03/2015

State Form Event ID: Y5PS11 Facility ID: 012685 If continuation sheet Page 11 of 24

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPI		X1) PROVIDER/SUPPLIER/CLIA				(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPL	ETED
		15K080	B. Wl	NG		03/27/	2015
E 0E B				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER			107 FEI	DERAL DRIVE		
	LES HOMECARE L	LC		CHEST	ERFIELD, IN 46017		
(X4) ID		FATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION DEFETY (EACH CORRECTIVE ACTION SHOULD B		(X5)	
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	COMPLETION DATE
TAG		<u> </u>		TAG	hands. To remove soil and		DATE
		en Employee E took off			transient organisms from the		
	her gloves after removing clothing from patient #3, she applied clean gloves				hands and reduce total microb	ial	
					counts over time. Each employ	/ee	
		her hands. This was			received a competency	£	
	prior to giving a	shower to patient #3.			evaluation check off by an RN handwashing procedure. All st	aff	
	2. On 3/25/15 at	2:37 PM, Employee A,			will follow policies in place. The RNs will observe that these	Э	
		r, indicated Employee E			policies are being enforced du	ring	
	did not follow in				their supervisory visits of the	5	
	procedures. 3. The agency procedure titled "Standard				home health aides. The		
					DON/ADON will ensure that th		
					deficiency is corrected and will not occur in the future		
		l Procedures for Home			not occur in the lattire		
		e of August 2002 stated,					
		Fore and after client care.					
	wash hands oct	ore and arter elient care.					
N 522	410 IAC 17-13-1(a	1)					
	Patient Care						
Bldg. 00		Medical care shall follow					
	-	plan of care established viewed by the physician,					
	dentist, chiropracte						
	podiatrist, as follow						
	Based on clinical	l record and agency	N 5	22	The DON/ADON held a meetir	ng	04/03/2015
	policy review an	d interview, the agency			with all RN's and LPN's. The		
	failed to ensure s	services had been			inservice education meeting content included discussion of	the	
	provided in acco	rdance with physician			policy "Standards of practice",	u IC	
	-	£ 5, #7) of 10 records			Policy #C-110. The meeting w	as	
	reviewed.				held on 4/3/2015. Policy include		
					in section #3 of this policy that		
	The findings incl	lude:			client care will be provided und the Plan of Care established b		
					physician. All nursing visits are	-	
	Regarding blood	pressures omitted at			be followed by the orders on the		
	skilled nurse visi	-			plan of care signed by the		
	Skilled lidibe visi	•••			physician. Instructed the RN's and LPN's that if the informal		
					caregiver and/or power of		

State Form Event ID: Y5PS11 Facility ID: 012685 If continuation sheet Page 12 of 24

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		JILDING	00	COMPLETED	
		15K080	B. W	ING		03/27/2	2015
NAME OF E	PROVIDER OR SUPPLIER		•	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	ROVIDER OR SUFFLIER			107 FE	DERAL DRIVE		
	LES HOMECARE L			CHEST	ERFIELD, IN 46017		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	``	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	TΕ	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	attorney for the patient has		DATE
		d #2, start of care			requested something to not be		
	8/20/12 with a d	•			done that is on the care plan,		
		ncluded a plan of care for			physician must be notified and		
	the certification	period of 2/18/15 -			careplan updated. The RN's a		
	2/18/15. This pl	an of care evidenced			LPN's reeducated that vital sig	ns	
	vital signs would	l be done at each skilled			include all the following: blood	ne	
	nurse visit. At s	killed nurse visits on			pressure, heart rate, respiration and temperature, If one of these		
	2/18/15, 2/19/15	, 2/20/15, 2/21/15,			are requested to be omitted, the		
	2/22/15, 2/23/15	, 2/24/15, 2/25/15,			physician is to be notified and		
	•	, 2/28/15, 3/1/15, 3/2/15,			careplan should specifically		
	•	nd 3/6/15, blood pressure			reflect this. 10% of all clinical		
	was not taken.	F			records will be audited quarter for evidence that standards of	ly	
	was not taken.				practice/plan of care physician		
	2 Clinical recor	d #7, start of care 9/1/12			orders are being followed with		
					accuracy. Inservice education		
	and diagnosis of				meeting for clinical		
	· ·	ided a plan of care for			documentation policy #C-680	این	
	·	period of 2/18/15 -			held on 4/3/15 by DON/ADON a missed visit occurs, a missed		
	•	an of care evidenced			visit report will be completed.		
		l be done at each skilled			reason services were not		
		killed nurse visits on			provided and documentation to		
	•	, 2/20/15, 2/21/15,			include the physician was notif		
	2/22/15, 2/23/15	, 2/24/15, 2/25/15,			The nursing staff will follow this policy that is in place. 10% of a		
	2/26/15, 2/27/15	, 2/28/15, 3/1/15,			clinical records will be audited	ווג	
	3/2/15, 3/3/15, 3	/5/15, and 3/6/15, blood			quarterly for evidence that all		
	pressure was not	taken.			visits are being followed on the	,	
					plan of care signed by the		
	On 2/26/15 a	at 1:35 PM, Employee A,			physician, or that a missed vis		
		r, indicated the plan of			report was completed, reason the missed visit and that the	IOF	
		n written correctly for			physician was notified per police	_{cy}	
		#2 and #7. The informal					
		wer of attorney for the					
		want the patients to have					
	_	done at each visit.					
	orood pressures	done at each visit.					

State Form Event ID: Y5PS11 Facility ID: 012685 If continuation sheet Page 13 of 24

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA		(X2) M	SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 15K080	A. B. W	UILDING TNG	00	COMPL 03/27/		
		1311000	<i>5.</i> "		DDDDGG CVTV CT TT TT TT TT	03/2//	2010	
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE DERAL DRIVE			
LIFESTY	LES HOMECARE L	LC	CHESTERFIELD, IN 46017					
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)	
PREFIX TAG	·	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE	
1710	REGUENTORT OR	ESC IDENTIFY TING IN ORDER THON	+	1710	·		DATE	
	Regarding a missivisit	sed home health aide						
	3. Clinical recor	d #5, start of care 4/1/14						
		osteoarthritis, included a						
	_	he certification period of						
	•	5. This plan of care						
	identified the ho	me health aide would						
	visit the patient 4	4 - 7 days a week.						
	health aide visits of 2/2/15 - 2/8/1:	rd evidenced 3 Home had occurred the week 5. These visits occurred 5, and 2/6/15. There was						
	· ·	n that the physician had						
		ue to the lack of visits.						
	A, administrator	15 at 4:05 PM, Employee						
	documented, not	· · · · · · · · · · · · · · · · · · ·						
	documented, not	done.						
	Care" with no da	olicy titled "Plan of the stated, "Professional otly alert the physician to suggest a need to alter						
N 540	410 IAC 17-14-1(a Scope of Services							
Bldg. 00	services are limite purposes of practi	(1)(A) Except where d to therapy only, for ce in the home health ered nurse shall do the						

State Form Event ID: Y5PS11 Facility ID: 012685 If continuation sheet Page 14 of 24

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 15K080		A. BUILDING <u>00</u> C			COMPL	O3/27/2015	
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 107 FEDERAL DRIVE CHESTERFIELD, IN 46017				
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	Based on clinical interview, the agregistered nurse assessment visit aide visited for 1 (#4). Findings include 1. Clinical record 2/26/15 and diagregistered a home conducted by the at 8 AM - 6 PM. start of care asses 1 PM - 2:30 PM. 2. On 3/26/15 at administrator, in assessment visit assessment had a Employee F were on 2/26/15 at 8 AM.	rds #1, start of care gnosis of hyponatremia, e health aide visit e Employee F on 2/26/15 The RN conducted the ssment on 2/26/15 from t 4 PM, Employee A, dicated the initial and start of care (SOC) not occurred when the it out to visit the patient	N 5	40	The DON/ADON held an inservice/education meeting of 4/3/15 for all staff regarding the policy for admission of a patient. The policy indicates the service will be initiated after the assessment by the RN, unless documentation supports alternate plans based on the client need and wishes. The deficiency indicated the home health aide completed a home visit prior to the RN doing the initial assessment visit. Reeducation completed to all the home heal aides that if they would happed receive a call by a client need in them to come for their care, the home health aide must first not the office so that coordination the start of care is effective for the safety of the client and the caregiver. The RN is reeducated to inform the client that he/she must notify the office of any hospital admission or discharges that the much needed care not overlooked by the agency avoid the client being without the correct care. This policy will be followed by all staff	e e nt. es s ate ds e lith to ng e tiffy of ed e is and he	04/03/2015
N 550 Bldg. 00	services are limite purposes of practi setting, the register following:						

State Form Event ID: Y5PS11 Facility ID: 012685 If continuation sheet Page 15 of 24

		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		JILDING	00	COMPL	
		15K080	B. Wl	ING		03/27/	2015
NAME OF F	DOMINED OD GUIDDI TER)		STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIEF		107 FEDERAL DRIVE				
	LES HOMECARE L				ERFIELD, IN 46017		
(X4) ID		TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		nd other individuals as	+	TAG	DEFICIENCY)		DATE
	appropriate.	nd other individuals as					
			N 5	50	The DON/ADON held an		04/03/2015
	Rased on agency	policy review, clinical	11,3	30	inservice/education meeting for	r	04/03/2013
		• •			all RN's on 4/3/15 to review th		
	•	nd interview, the agency			policy for "Careplans" Policy #		
		the registered nurse			C-660. The survey deficiency	20	
	_	he health aide plan of care			recognized one of the careplant were not signed by an RN that		
	_	days as required by			was reviewed during the 60da		
		1 of 7 clinical records			recertification visit. All RN's	,	
	reviewed of pati	ents receiving home			reeducated that the policy read		
	health aide services (#3).				the care plan shall be reviewe	d,	
					evaluated and revised at a	d ==	
	Findings include	e:			minimum of every 60 days and needed based upon the clients		
	_				health status, ongoing client	•	
	1. The policy tit	tled "Home Health Aide			assessments, caregiver suppo	ort	
		no date stated, "The			systems, and effectiveness of	the	
		are Plan shall be reviewed			interventions in achieving		
		the registered nurse			progress toward goals. All	_1	
	minimally every	•			updated entries must be signe and dated by the Registered	a	
		oo days.			Nurse. All changes will be		
	2 (1: : 1	1.1/2			communicated to appropriate		
		rd #3, start of care			staff members. This policy will		
		ed a physician's plan of			followed by evidence of clinica	ıl	
		tion period 3/13/15 -			records to be free of this		
		cord evidenced an aide			deficiency with each quarterly evaluation of a minimum of 10	0/2	
	care plan with re	eview dates of 7/18/14,			of clinical records reviewed.	70	
	9/11/14, 11/10/1	4, and 3/11/15.					
	3. On 3/26/15 a	t 3:26 PM, Employee A,					
	the administrator	r, indicated the aide care					
		eviewed every 60 days.					
		. <i>y</i>					
N 597	410 IAC 17-14-1(I						
	Scope of Services	3					

State Form Event ID: Y5PS11 Facility ID: 012685 If continuation sheet Page 16 of 24

STATEMENT OF DEFICIENCIES X1) PROVID		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SUR			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPLETED	
		15K080	B. W	ING		03/27	/2015
				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER				DERAL DRIVE		
LIFESTY	LES HOMECARE L	LC			ERFIELD, IN 46017		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE.	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
Bldg. 00	Rule 14 Sec. (1)(I) shall:	(1) The home health aide					
	(B) be entered on	and be in good standing					
	on the state aide r	egistry.					
			N 5	97	Based on this deficiency above	e h	03/30/2015
	Based on policy	and employee file review			the following addendums have		
		e home health agency			been made to the home health		
	•	nome health aides were			aide hiring requirements. If a C is hired to fill a home health aid		
					position the CNA must comple		
		n good standing on the			and pass the written home hea		
	state aide registry for 2 of 4 home health				aide exam. The CNA must als		
	aide files review	ed (F, G).			complete the competency		
					evaluation check off with		
	Findings:				proficiency by the RN. The how health aide must be entered or		
	4 5 4 54	T. 1			and in good standing with the		
		e F, date of hire 4/9/13			state aide registry. A copy of the	ne	
	•	contact 4/15/13, failed to			employees current license		
	evidence the hon	ne health aide was			certification shall be maintaine		
	entered on and in	n good standing on the			his/her personnel file. The CN		
	state aide registr				in question on the deficiency w	/ere	
		,			corrected on 3/30/15		
	2. Employee Fil	e G, date of hire 3/28/14					
	and first patient	contact 3/29/14, failed to					
	•	ne health aide was					
		n good standing on the					
		_					
	state aide registr	y.					
	3 On 3/27/15 at	10:45 AM, Employee A,					
		dicated Employees F and					
		ed on the state aide					
	registration as ho	ome health aides.					
	4. The agency policy titled "License,						
	Registration, or o						
	_						
	-	ith no date stated, "If a					
	position requires	certification, it shall					

State Form Event ID: Y5PS11 Facility ID: 012685 If continuation sheet Page 17 of 24

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X1) PROVIDER/SUPPLIER/CLIA	X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPL	ETED
		15K080	B. W	ING		03/27/	2015
NAME OF D	ROVIDER OR SUPPLIER		<u> </u>	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	KO VIDER OR SOIT EIER		107 FEDERAL DRIVE				
LIFESTY	LES HOMECARE L	LC		CHEST	ERFIELD, IN 46017		
(X4) ID		TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCI)		DATE
		's responsibility to keep					
		current a copy of the					
		ent license certification					
		ned in his / her personnel					
	file."						
N 606	410 IAC 17-14-1(n	,					Į.
Bldg. 00	Scope of Services Rule 14 Sec. 1(n)	A registered nurse, or					
Diag. 00		y only cases, shall make					
		ne patient's residence and					
	•	ry visit at least every thirty					
		when the home health aide nt, to observe the care, to					
		ps, and to determine					
	whether goals are						
			N 6	06	The DON/ADON held an inservice/education meeting w	ith	04/03/2015
	Dagad on nation	and clinical record			the RN's in regards to the		
		view, the agency failed to			deficiency of frequency of		
		ered nurse (RN) made an			supervising the home health aides. The RN's were schedule	ed he	
	-				to complete a supervisory visit		
		e patient's home no less every 30 days in 4 of 4			every 60 days on non skilled		
		-			patients and every 14 days on		
		of patients receiving			skilled patients. This process vectors being done in error. The state	vas	
		e only services (#3, #5,			regulations state the home hea	alth	
	#6, #10) for over	30 days.			aides are required to have a		
	The findings incl	lude:			supervisory visit every 30 days non skilled patients and 14 day		
					on skilled patients. The agency		
	1. Clinical recor	rd 3, start of care (SOC)			policy was revised immediately and all RN's educated on this	У	
	7/17/14 and diag	nosis of arthritis,			process. The policy shall provi	de	
	included plans of	of care for the			home health aide services und		
	certification peri	ods of 1/12/15 - 3/12/15			the direction and supervision of		
	and 3/13/15 - 5/1	1/15. The plan of care			registered nurse when persona		
	for the certificati	on period of 1/12/15 -			care services are indicated and ordered by the physician. The	a	

State Form Event ID: Y5PS11 Facility ID: 012685 If continuation sheet Page 18 of 24

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPL	ETED
		15K080	B. W	ING		03/27/	2015
				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER	2			DERAL DRIVE		
LIFESTY	LES HOMECARE L	LC			ERFIELD, IN 46017		
(X4) ID		TATEMENT OF DEFICIENCIES	T	ID	,		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΓE	DATE
		l orders for the HHA to			purpose is to observe the aide	in	
					providing care to the patients a		
	visit 2- 4 hours a day, 5 - 7 days a week, 3 - 4 days a week for 8 weeks to assist with shower, shampoo, bathing, dressing, nail / skin / oral / hair care . HHA will provide medication reminders diabetic menu planning and menu preparation. The second plan of care for the				to assess competency in basic		
					skills as well as delegated nurs		
					tasks. One specific RN has be	en	
					assigned to schedule these supervisory visits and another	DNI	
					has been assigned to keep an		
			1		audit flow sheet to ensure that		
			1		supervisory visits are being		
	certification peri	od of 3/13/15 - 5/11/15			completed timely.		
	included orders	for the HHA to visit 2 - 4					
	hours a day, 0 -	1 day / week, and 2 - 4					
		days a week for weeks 2					
	1	by the RN did not occur					
	every 30 days.	Toy the feet and not occur					
	every 50 days.						
	Δ The RN	visited the patient and					
		visory visits on 1/8/15					
		VISOLY VISITS OII 1/8/13					
	and 3/11/15.						
	D 771 1	1 14 11 17 1					
		e health aide completed					
		5, 1/13/15, 1/14/15,					
	· ·	, 1/19/15, 1/20/15,	1				
	1/21/15, 1/22/15	, 1/23/15, 1/26/15,					
	1/27/15, 1/28/15	, 1/30/15, 2/3/15, 2/4/15,					
	2/5/15, 2/6/15, 2	/9/15, 2/10/15, 2/11/15,					
		, 2/18/15, 2/20/15,	1				
		, 2/25/15, 2/27/15,	1				
	· ·	/6/15, 3/9/15, 3/11/15,	1				
	and 3/13/15 and		1				
	and 3/13/13 and	J 4J 1J,					
	C On 2/26/	15 at 3:45 PM, Employee					
		ator, indicated the					
		s had not occurred every					
	30 days						

State Form Event ID: Y5PS11 Facility ID: 012685 If continuation sheet Page 19 of 24

		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING 00 COMPLETED				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:			00		
		15K080	B. W.	ING		03/27/	2015
NAME OF F	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP CODE		
LIFECTV		1.0			DERAL DRIVE		
	LES HOMECARE I	_LC		CHEST	ERFIELD, IN 46017		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	,	ICY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION DATE
IAG	REGULATORT OR	LESC IDENTIFY INCOMMATION)		IAG	,		DATE
	2 Clinical reco	rd 5, SOC 4/1/14 and					
		eoarthritis, included plans					
	_						
	of care for the certification periods 11/27/15 - 1/25/15 and 1/26/15 - 3/26/15.						
		for certification period					
	•	25/15 had home health					
		ed for week 1 : 4-8 hours					
		ys per week and week 2 -					
	-	day, 4 - 7 days per week					
	•	ower, shampoo, bathing,					
		ssing and nail / skin / oral					
	_	plan of care for the					
		iod of 1/26/15 - 3/26/15					
	•	aide visits ordered for					
		- 8 per day, 4 - 7 days per					
		ith shower, shampoo,					
		g / undressing and nail /					
		care. The agency failed					
		ervisory registered nurse					
	visits every 30 d	ays.					
	A The DNI						
	visits on 11/25/1	completed supervisory					
	VISITS OII 11/23/1	4 and 1/21/13.					
	р ть ии	A completed HHA visits					
		27/14, 11/28/14, 12/1/14,					
	· ·	2//14, 11/26/14, 12/1/14, 1, 12/4/14, 12/5/14,					
	· ·	., 12/4/14, 12/5/14, ., 12/10/14, 12/11//14,					
	,						
	· ·	/14, 12/16/14, 12/17/14,					
	· · · · · · · · · · · · · · · · · · ·	/14, 12/22/14, 12/23/14,					
	· ·	/14, 12/29/14, 12/30/14,					
	· ·	5, 1/2/15, 1/5/15, 1/7/15,					
	1/8/15, 1/9/15, l	/12/15, 1/13/15, 1/14/15,					

State Form Event ID: Y5PS11 Facility ID: 012685 If continuation sheet Page 20 of 24

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING 00 COMPLETED					
AND PLAN OF	F CORRECTION	IDENTIFICATION NUMBER:			00		
		15K080	B. W			03/27/	2015
NAME OF PRO	OVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
LIEECTVIII	EC LIOMECADE I	1.0			DERAL DRIVE		
	ES HOMECARE L	.LC		CHEST	ERFIELD, IN 46017		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION DATE
		· · · · · · · · · · · · · · · · · · ·	+	TAU			DATE
	•	, 1/19/15, 1/20/15, 1/22/15, 1/26/15					
	1/21/15, 1/22/15, 1/23/15, 1/26/15,						
	1/27/15, 1/28/15, 1/29/15, 1/30/15, 2/2/15, 2/4/15, 2/6/15, 2/9/15, 2/10/15,						
	•	, 2/13/15, 2/16/15,					
	•	, 2/19/15, 2/20/15,					
	2/23/13, 2/24/13 2/27/15, 3/2/15,	, 2/25/15, 2/26/15,					
	2/2//13, 3/2/13,	and 3/23/13.					
	C. On 3/26/	15 at 4 PM, Employee A,					
	the administrator						
	supervisory visit	•					
	completed every						
	1	•					
	3. Clinical recor	rd 6, SOC 8/14/14 and					
	diagnosis of seiz	ure disorder, included					
	plans of care for	the certification periods					
	of 12/12/14 - 2/9	/15 and 2/10/15 -					
	4/10/15. The pla	an of care for the					
	certification peri	od of 12/12/14 - 2/9/15					
	included orders f	For the HHA to visit 1 - 2					
	hours a day, 1 - 2	2 times a day, 2 - 3 days					
	•	and 1 - 2 hours a day, 5					
	- 7 days a week t	for weeks 2 - 8, and 1 - 2					
	hours / day, 1 - 2	times a day, 0 -1 days a					
	-	. The HHA was to					
	assist with show	er, shampoo, bathing,					
		ssing, nail / skin, oral /					
	hair / nail care.	The plan of care for the					
		od of 2/10/15 - 4/10/15					
	included orders f	For the HHA to visit 2 - 4					
	days / day, 5 - 7	days a week for 9 weeks.					
	HHA was to assi						
	shampoo, bathin	g, dressing / undressing,					

State Form Event ID: Y5PS11 Facility ID: 012685 If continuation sheet Page 21 of 24

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15K080		(X2) MULT A. BUILD B. WING		OO	(X3) DATE : COMPL 03/27/	ETED		
	PROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP CODE 107 FEDERAL DRIVE CHESTERFIELD, IN 46017					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		O EFIX AG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE	
	nail / skin, oral,	hair care.						
	A. The RN visits on 12/9/14	completed supervisory and 2/9/15.						
	on 12/12/14, 12/12/16/14, 12/17/12/20/14, 12/22/12/28/14, 12/29/17/2/15, 1/3/15, 11/8/15, 1/9/15, 1/13/15, 1/18/15, 1/19/15 1/22/15, 1/23/15 1/25/15, 1/26/15 1/30/15, 1/31/15 2/5/15, 2/13/15, 2/13/15, 2/14/15	ealth aide visits occurred (13/14, 12/14/14, 14, 12/18/14, 12/19/14, 14, 12/23/14, 12/24/14, 14, 12/30/14, 12/31/14, 15/15, 1/6/15, 1/7/15, 1/10/15, 1/11/15, 1/12/15, 1/15/15, 1/20/15, 1/21/15, 1/24/15, 1/24/15, 1/29/15, 1/28/15, 1/29/15, 1/21/15						
	diagnosis of den cares for the cer 12/3/14 - 1/30/1 The plan of care period of 12/3/1 orders for the HI	rd #10, SOC 8/5/14 and mentia, included plan of tification periods of 5 and 1/31/15 - 3/31/15. for the certification 4 - 1/30 /15 included HA to visit 2 - 4 hours a week, 3 - 5 days for the						

State Form Event ID: Y5PS11 Facility ID: 012685 If continuation sheet Page 22 of 24

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPL	ETED
		15K080	B. W	ING		03/27/	/2015
				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	C		107 FEI	DERAL DRIVE		
LIFESTY	LES HOMECARE I	LLC		CHEST	ERFIELD, IN 46017		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		2 - 4 hours / day, 3 - 5					
	days per week for 8 weeks. HHA was to						
	assist with shower, shampoo, bathing,						
	dressing / undres	ssing, nail / skin, oral,					
	hair care as tasks	s for both of these plans					
	of care.	•					
	A The RN	completed supervisory					
	visits on 12/2/14						
	VISIOS OII 12/2/1	. unu 1/20/10.					
	B Home h	ealth aide visits occurred					
		/14, 12/5/14, 12/8/14,					
	I	/14, 12/15/14, 12/17/14,					
	1						
	-	(14, 12/21/14, 12/22/14,					
	1	14, 12/30/14, 12/31/14,					
	· ·	/7/15, 1/14/15, 1/16/15,					
	1/19/15, 1/21/15	, 1/28/15, 1/30/15,					
	2/2/15, 2/13/15,	2/16/15, 2/18/15,					
	2/25/15, 2/27/15						
	C. On 3/24/	15 at 3:10 PM, Employee					
	A, the administr	ator, indicated the					
	supervisory visit	ts had not been					
	completed every						
		•					
	5. The agency po	olicy titled "Home Health					
		n" with an addendum					
	_	stated, "Agency shall					
		ealth aide services under					
	_						
		l supervision of a					
	_	e when personal care					
		cated and ordered by a					
	physician. The						
	supervision in re	esponse to Medicare					

State Form Event ID: Y5PS11 Facility ID: 012685 If continuation sheet Page 23 of 24

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K080	ì í	JILDING NG	onstruction 00	(X3) DATE COMPI 03/27	LETED
NAME OF PROVIDER OR SUPPLIER LIFESTYLES HOMECARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 107 FEDERAL DRIVE CHESTERFIELD, IN 46017				
(X4) ID	SUMMARY S'	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	or federal require regulations indic does not require nurse, a registere	ney policy and other state ements the state ate that a patient who the skilled services of a ed nurse must make a to the patient's residence ry 30 days."					

State Form Event ID: Y5PS11 Facility ID: 012685 If continuation sheet Page 24 of 24